Supreme Court, U.S.
FILED
04-566 SEP 27 2004
OFFICE OF THE CLERK

No.

IN THE
SUPREME COURT OF THE UNITED STATES

UNITED STATES OF AMERICA, *EX REL*, J. EDWARD WALTERS,

Petitioner,

v.

THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., AND ASCENSION HEALTH, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS FOR REVIEW

1. Whether submitting a false Annual Cost Report to Medicare which will influence future payment rates is a violation of the Federal False Claims Act.

2. Whether the Eleventh Circuit's decision in this case is in conflict with decisions of the Tenth, Fourth and D.C. Circuits.

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LIST OF PARTIES

The parties are listed in the caption of the case.

CORPORATE DISCLOSURE STATEMENT

All of the Defendants claim to be non-profit corporations. They are affiliated with the Catholic Church, but the nature of the affiliation is unknown to Petitioner. Defendant Ascension Health, Inc. is the successor-in-interest to Daughters of Charity National Health System, Inc. None of the Defendants/Respondents issues publicly traded stock, to Petitioner's best knowledge.

CITATIONS TO OPINIONS BELOW

Neither the Appeals Court decision, nor the District Court opinion was published. The Eleventh Circuit Cause No. is 04-10915, the District Court for the Southern District of Alabama, Southern Division No. is 99-0932-CB-C.

For reasons unknown, the Eleventh Circuit changed the style of the case. The style listed on the cover page of this document is the style of the case in the District Court.

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

The Eleventh Circuit opinion and judgement was filed on July 2, 2004.

STATUTES

31 U.S.C. § 3729

(a) Liability for certain acts. -- Any person who --

(1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

(2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;

(3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;

••••

is liable to the United States Government...

42 U.S.C. § 1395ww

(f) Reporting of costs of hospitals receiving payments on basis of prospective rates

(1)(A) The Secretary shall maintain a system for the reporting of costs of hospitals receiving payments computed under subsection (d) of this section.

RULES OF PROCEDURE

FRCP 9(b)

Fraud, Mistake, Condition of the Mind. In all averments of fraud or mistake, the circumstances constituting fraud or

mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.

STATEMENT OF THE CASE

Course of Proceedings and Disposition in the Courts Below

Plaintiff filed an action under the Federal False Claims Act, 31 U.S.C. § 3729 et seq., against the Daughters of Charity National Health System, Inc. which at the time in question owned or managed a number of hospitals throughout the United States, including Providence Hospital in Mobile, Alabama, Providence Hospital itself, Seton Medical Management, Inc., which provided services to Providence Hospital and Ascension Health, Inc. which, at some point assumed the assets and liabilities of Daughters of Charity.

Defendants filed motions to dismiss claiming Plaintiff had failed to state a claim pursuant to Federal Rules of Civil Procedure 9(b) and 12(b)(6). The District Court, in its order of January 28, 2004 granted Defendants' motions and dismissed the case.

Appeal was taken to the United States Court of Appeals for the Eleventh Circuit, which affirmed the dismissal on July 2, 2004.

Statement of Facts

Petitioner J. Edward Walters worked for Providence Hospital from 1988 until March, 1998. He was, at the time he

was terminated, Director of the Diabetes Center, the Cholesterol Center and the Employee Assistance Program.

In January, 1998, each director of department at the hospital became responsible for his or her department's billing, including the accuracy of billing. In reviewing the medical records and bills for patients, Walters noticed that patients were being billed for drugs and medical supplies which they did not receive.

When he questioned persons involved with billing, he learned that this was systemic.

Walters copied one Medicare patient's medical records and bill. (F.G.) By comparing the medication administration records and the itemized bill, Walters determined that the overcharges for drugs, supplies and tests which were not received by the patient were at least $1,185.03.

He later discovered that Providence Hospital submitted a claim to Medicare which included an itemized bill containing the overcharges.

Under the Prospective Payment System now in effect for most hospital medicare reimbursement, hospitals are paid based upon the main diagnosis of the patient in question. Thus, even though the bill for the patient whose record Walters copied totaled $35,464.04, Providence Hospital was only paid $19,682.53.

However, as required by statutes and regulations governing Medicare, Providence Hospital submitted its Annual Cost Report for the relevant period. This report

included "Medical Supplies Charged to Patients" and "Drugs Charged to Patients." These charges were almost $7,000,000.00.

Walters alleged that "These figures undoubtedly contain the overcharges to patient F.G. and, because these types of overcharges are systemic to Providence Hospital, the Cost Report submitted by Providence Hospital is greatly overstated as to drugs and medical supplies for patients."

Walters also alleged that, "The overcharges became a part of the computations considered by the Health Care Financing Administration, and assuming that the same system is in place, continue to be part of the computations by the Center for Medicare and Medicaid Services, which help to determine reimbursement rates for hospitals."

Walters attached copies of the pertinent medical records, bill, claim to Medicare and Cost Report to the pleadings considered by the District Court and Appeals Court. The facts, as stated above are undisputed, as found by both courts.

ARGUMENT

Petitioner attached the itemized statement which the hospital sent to Medicare in order to be reimbursed. The statement contained charges for drugs and medical supplies which were not received by the Medicare beneficiary.

Under the current payment scheme, the hospital did not **immediately** receive payment for the overcharges. However, the hospital included these overcharges in its

Annual Cost Report submitted to Medicare pursuant to Federal Statutes (42 U.S.C. § 1395ww, specifically (f)(1)(A)).

The hospital had to submit a statement of the services it provided for the Medicare patient. The False Claim Act prohibits presenting a false claim for payment. 31 U.S.C. § 3729(a)(1).

Recognizing that hospitals are not paid the total amount that they claim they spent on a given Medicare patient, but are reimbursed, based in part by what the Federal Government determines to be the average cost of providing care to all Medicare patients. Petitioner included portions of the hospital's Annual Cost Report for the relevant period.

The court below decided for the hospital because it did not immediately receive any extra money by reason of either the initial claim or the Cost Report for that year. Thus, if the ruling is allowed to stand it means that hospitals may inflate their costs which are then used by the Secretary of Health and Human Services to determine the hospitals' reimbursement rates.

Obviously, such blatant overstatement of costs has grave consequences for the Treasury of the United States. The question involved in this Petition is whether it may be dealt with under the False Claims Act.

The court below stated that:

> "'Without the presentment of...a [false or fraudulent] claim, while the practices of an entity that provides services to the

> Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the FCA.' United States ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1311 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003)."

The ruling conflicts with rulings by at least three other circuit courts of appeal.

The Tenth Circuit in *Kennard v. Comstock*, 363 F.3d 1039 (2004) dealt with a case alleging fraudulent underpayment of oil royalties to an Indian tribe. The royalties, in question were not paid to the U.S. Government, but were transmitted to the Mineral Management Service of the United States Department of the Interior. Under the pertinent regulations, the Mineral Management Service is to have "a comprehensive...accounting and auditing system...to accurately determine oil and gas royalties." 363 F.3d at 1048.

The public fisc of the United States was in no way damaged by the actions of the Defendant in *Kennard.*

The Fourth Circuit in *Harrison v. Westinghouse Savannah River Company*, 352 F. 3d 908 (2003), affirmed an award of attorneys fees in a False Claims Act case where the Defendant had submitted a false certification but no actual damages were proved.

The Fourth Circuit in a previous decision in the same case stated that liability under the False Claims Act must meet a judicially imposed standard of materiality, which depends

on "whether that false statement has a natural tendency to influence agency action or is capable of influencing agency action." *Harrison v. Westinghouse Savannah River Company*, 176 F. 3d 776, 785 (4th Cir. 1999).

Arguably, the District of Columbia Circuit lines up with the Fourth and the Tenth, at least according to *Pogue v. Diabetes Treatment Centers of America, Inc.*, 238 F. Supp. 2d 258 (D.C. D.C., 2002) which held that by submitting a claim the Defendant impliedly certified that it had complied with all statutes and regulations.

Section 1395ww of Title 42, United States Code sets out the criteria for payments to hospitals for inpatient hospital services to Medicare beneficiaries. The provision is voluminous and is on a par with the Internal Revenue Code for difficulty. However, throughout the section words such as "the average of such costs for all hospitals in the same grouping," appear and indicate that such averages shall be used by the Secretary of Health and Human Services to determine the reimbursement rate to hospitals for care of Medicare patients.

Although not immediately reimbursed, the individual claims and the Annual Cost Reports submitted by hospitals contribute to the averages considered by the Secretary in determining reimbursement rates. By inflating its costs for drugs and medical supplies, Defendant hospital's false statements had "a natural tendency to influence agency action or [was] capable of influencing agency action." *Harrison*, 176 F. 3d at 785.

Whether Defendant Providence Hospital has received

any extra funds by reason of its false claims and cost reports is, of course, subject to proof. However, Providence Hospital is one of many hospitals owned by Defendant Ascension Health, Inc. which, according to its website, claims to have facilities in twenty states. (www.ascensionhealth.org)

Even if the price Medicare pays for various hospital procedures only increases by a few dollars per patient, the cost to the Government increases by millions or more. In March of this year, the Medicare Board of Trustees reported to Congress that Medicare's financial condition has significantly deteriorated, partly because of exploding health costs. New York Times, March 24, 2004, page 1.

CONCLUSION

Congress has given the courts a powerful weapon to combat fraud against the Treasury. But, if the courts are going to allow individuals and corporations to scam the system because False Claim Act plaintiffs have not participated in the fraud and thus, do not have insider knowledge, as was the situation in this case, the weapon is ineffectual for the great majority of fraud against the Government and taxpayers.

The court should grant certiorari and allow Petitioner to help save Medicare by exposing the huge overstatement of costs by hospitals.

Respectfully submitted,

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APPENDIX

[DO NOT PUBLISH]

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 01-10915 [FILED
Non-Argument Calendar JULY 02, 2004]

D. C. Docket No. 99-00392-CV-1-CB-C

J. EDWARD WALTERS, bringing this action on behalf of the United States of America,

Plaintiff-Appellant,

versus

DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, INC., d.b.a. Providence Hospital, SETON MEDICAL MANAGEMENT, INC., PROVIDENCE HOSPITAL, ASCENSION HEALTH, Ascension Health, Inc.,

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Alabama

(July 2, 2004)

Before ANDERSON, MARCUS, and PRYOR, Circuit Judges.

PER CURIAM:

Qui tam relator, J. Edward Walters, appeals the district court's dismissal of his claim under the False Claims Act ("FCA"), 31 U.S.C. § 3729 et seq., for failure to plead fraud with particularity and failure to state a claim. On appeal, Walters argues that his complaint sufficiently alleged FCA claims arising from the alleged practice of overcharging for prescription medicines and medical supplies by Defendant, Providence Hospital ("Providence").[1]

We review de novo the dismissal of a complaint for failure to state a claim, accepting all allegations contained in the complaint as true and construing the facts in a light most favorable to the plaintiff. See Harper v. Thomas, 988 F.2d 101, 103 (11th Cir. 1993). A complaint may not be dismissed "unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." Pataula Elec. Membership Corp. v. Whitworth, 951 F.2d 1238, 1240 (11th Cir.) (quoting Scheuer v. Rhodes, 416 U.S. 232, 236 (1974)), cert. denied, 506 U.S. 907(1992).

Upon thorough review of the record, as well as careful consideration of the parties' briefs, we find no reversible error and affirm.

The relevant facts, as found by the district court, are undisputed. Walters was formerly the Director of the Diabetes Center, the Cholesterol Center, and the Employee Assistance Program, all located at Providence Hospital in Mobile, Alabama, where Walters was employed from March

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[1] Walters also sued Seton Medical Management, Inc., and Daughters of Charity National Health System ("Daughters of Charity"), both of whom participate in the ownership and/or management of Providence. Defendant Ascension Health, Inc. is the successor-in-interest to Daughters of Charity.

1988 through March 1998. According to Walters's complaint, he was terminated shortly after he discovered the billing practices that form the basis of his suit.

Walters alleged that Providence had provided health care services to beneficiaries of Medicare, Medicaid, and other federally-funded programs and was a participating provider with the Center for Medicaid Services, formerly the United States Health Care Financing Administration. In January 1998, Providence delegated responsibility for billing practices to the directors of its various departments. In reviewing those bills for which he was responsible, Walters alleges that he determined there were discrepancies between the bills and the medical records for some former patients. Walters alleged that he had reviewed a number of patients' bills and records and found a pattern of charges for drugs and supplies that were not received by the patients.

Walter copied only one patient's record. Thus, the complaint's only reference to specific overcharges concerned a patient referred to as "F.G." Walters alleged that F.G. was in the hospital from June 4 to June 10, 1997 and that Providence had submitted a Medicare claim for services rendered. According to Walters, the bill sent to Medicare included $1,185.03 in overcharges for drugs and medical supplies never provided to F.G.

Notably, based on the method of reimbursement used under the Medicare system, Providence never received payments from Medicare for the alleged overcharges associated with F.G. As Walters concedes, the alleged overcharges were not used in calculating the final amount submitted for reimbursement to Medicare. The district court explained the Medicare reimbursement system as follows:

> To determine whether any of plaintiff's claims allege a cause of action under the FCA, it is necessary to understand, first, how the Medicare reimbursement system operates. Medicare does not reimburse a healthcare provider for the actual charge submitted, nor is the reimbursement based upon that amount. Instead, "Medicare groups standardized medical codes for patients, diseases, and procedures into diagnostic related groups ('DRG') that provide the basis for [the] PPS [prospective payment system]. The average cost of care for each DRG determines the reimbursement amount, rather than the actual cost of care to a beneficiary." United States v. Whiteside, 285 F.3d 1345, 1346 (11th Cir. 2002). Health care providers are reimbursed at a preestablished flat rate for each DRG. Transitional Hops. Corp. of Louisiana, Inc. v. Shalala, 222 F.3d 1019, 1021 (D.C. Cir. 2000). . . .
>
> Annual cost reports submitted by the health care provider are part of the reimbursement equation because they include certain costs, such as outlier costs, that may be reimbursed by Medicare in addition to those costs taken into account in the PPS/DRG payments.

District Court Order at 7-8.

In 1997, Providence submitted its annual Cost Report, which covered the relevant time period from July 1,1996 through

June 30,1997. The Cost Report states that Providence's annual costs for "Medical Supplies" totaled $3.3 million, while its total annual costs for "Drugs Charged to Patients" totaled $3.6 million.

In his complaint, Walters conceded that Providence was reimbursed by Medicare pursuant to the above-described PPS/DRG system, and that Medicare never paid the overcharged amount. Walters contended that the United States was, nevertheless, damaged by Providence's inclusion of the overcharges in the initial claims -- the claims that were not used in calculating the reimbursement amount -- and the Cost Report. Walters further alleged that the "thousands of other[] [overcharges] . . . were undoubtedly submitted [thereby] affect[ing] the overall reimbursement rates of hospitals, including Providence Hospital and the hospitals affiliated with the other defendants. While the amount attributable to defendants may be difficult to calculate, it is real and substantial." Walters sought treble damages and penalties, pursuant to the FCA, as well as attorneys' fees, costs, and an appropriate award for himself for bring the qui tam claim.

Defendants moved to dismiss Walters's complaint, alleging that it failed to allege fraud with particularity, as required by Fed. R. Civ. P. 9(b), and that it failed to state an FCA claim and thus, warranted dismissal pursuant to Fed. R. Civ. P. 12(b)(6). The district court granted the motion, concluding that (1) Walters's general allegations of "systematic" overbilling were "broad and conclusory" and insufficient to plead a fraud claim under Rule 9(b); and (2) Walters's specific allegations of overbilling with respect to one patient, F.G., were insufficient to state an FCA claim because the alleged overcharges were not material to the decision on the Medicare reimbursement amount, which is determined by a fixed schedule predetermined by Medicare (the PPS/DRG system). This appeal followed.

The FCA imposes liability on "[a]ny person who . . . knowingly presents, or causes to be presented, to an officer or employee of the United States Government. . .a false or fraudulent claim for payment." 31 U.S.C. § 3729(a)(1). "Without the presentment of. . . a [false or fraudulent] claim, while the practices of an entity that provides services to the Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the FCA." United States ex rel. Clausen v. Lab. Corp. of Am., 290 F.3d 1301, 1311 (11th Cir.2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003).

We have held that a False Claims Act relator alleging a health plan administrator improperly submitted claims to Medicare must comply with Rule 9(b). See United States v. Laboratory Corp. of Am., Inc., 290 F.3d 1301, 1308 (11th Cir. 2002), cert. denied, 537 U.S. 1105, 123 S. Ct. 870, 154 L. Ed. 2d 774 (2003). Rule 9(b) provides that "[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity." Fed. R. Civ. P. 9(b). When Rule 9 is implicated, plaintiffs must plead not only the general nature of their injuries but also the specifics of how and when they were injured. See, e.g., Brooks v. Blue Cross & Blue Shield of Fla., Inc., 116 F.3d 1364, 1380-81 (11th Cir. 1997). Under Rule 9(b), a plaintiff alleging fraud must plead "(1) the precise statements, documents, or misrepresentations made; (2) the time, place, and person responsible for the statement; (3) the content and manner in which these statements misled the Plaintiffs; and (4) what the defendants gained by the alleged fraud." Id.

Here, the district court held that the complaint's general allegations of fraud, consisting of "broad and conclusory" statements, were insufficient under Rule 9(b). We agree. We are unpersuaded by Walters's reliance on our decision in United States

ex rel. Hill v. Morehouse Med. Assocs., Inc., 2003 WL 22019936 (11th Cir. Aug. 15, 2003). Unlike in Hill, Walter was not an insider who had observed and participated in the billing process and Walters did not have firsthand knowledge of the billing practices at issue here. Rather, as the district court found, "Plaintiff's similarity with Hill begins and ends with the fact that he is a former employee of one of the defendants." Simply put, pursuant to Clausen, conclusory allegations of fraudulent billing do not satisfy Rule 9(b)'s requirements and cannot support an FCA claim. We likewise find no error in the district court's Fed. R. Civ. P. 12(b)(6) analysis of Walters's more specific allegations of fraud.

AFFIRMED.

(2) me Court, U.S.
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No.

IN THE
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UNITED STATES OF AMERICA, *EX REL*, J. EDWARD WALTERS,

Petitioner,

v.

THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., AND ASCENSION HEALTH, INC.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

SUPPLEMENTAL APPENDIX CONTAINING DISTRICT COURT OPINION

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IN THE UNITED STATES DISTRICT COURT
FOR THE
SOUTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION

UNITED STATES OF AMERICA, *ex rel.* J. EDWARD WALTERS, Plaintiff,	)	
v.	)	CIVIL ACTION NO. 99-0932-CB-C
THE DAUGHTERS OF CHARITY NATIONAL HEALTH SYSTEM, PROVIDENCE HOSPITAL, SETON MEDICAL MANAGEMENT, INC., and ASCENSION HEALTH, INC., Defendants.	)	

MEMORANDUM OPINION and ORDER

This action involves a *qui tam* claim under the False Claims Act (FCA), 31 U.S.C. §§ 3729-33, by relator Edward Walters arising from Medicare reimbursements claims submitted by defendant Providence Hospital. Defendants have filed a motion to dismiss the second amended complaint ("the complaint") for failure to plead fraud with particularity and for failure to state a claim. In response to the motion, Walters asserts that his claim is both properly pled and legally sufficient. After reviewing the complaint and the issues raised in light of the applicable law, the Court finds that the motion to dismiss is

due to be granted.

Facts

J. Edward Walters was formerly Director of the Diabetes Center, Director of the Cholesterol Center and Director of the Employee Assistance Program at Providence Hospital in Mobile, Alabama. Walters was employed by Providence Hospital from March 1988 through March 1998. According to the complaint, Providence terminated Walters' employment shortly after he uncovered the billing practices that are the subject of this lawsuit.

Defendant Providence Hospital, a not-for-profit corporation incorporated under the laws of Alabama, is located in Mobile, Alabama. During the time relevant to this action, Providence provided health care services to beneficiaries of Medicare, Medicaid, and other federally-funded programs and was a Participating Provider with the United States Health Care Financing Administration (HCFA) and its successor agency, the Center for Medicaid Services (CMS). According to the complaint, defendants Seton Medical Management, Inc. (Seton), and Daughters of Charity National Health System (Daughters of Charity) participated in the management and/or ownership of Providence, and defendant Ascension Health, Inc. (Ascension) is the successor-in-interest to Daughters of Charity.

In January 1998, each department head at Providence became responsible for his or her department's billing, including responsibility for the accuracy of billing. Walters began to review bills and medical records for prior patients. Comparing patients' bills with medical records, Walters noticed "that patients were billed for certain drugs and other supplies which were not actually administered to them." Second Am. Compl ¶ 14. Walters "reviewed a number of

patients' bills and records which followed the same pattern of charges for drugs and supplies not received[.]" *Id.* ¶ 15. According to Walters, "the process of overbilling for drugs and medical supplies which were not actually received by the patients was part of the billing system which contained little if no [sic] procedures to credit a patient's account for drugs and medical devices which were initially charged to the patient, but were not actually received." *Id.* ¶ 42.

Walters copied only one patient's record, and, therefore, his only reference to specific instances of overcharges relate to that patient, whom the complaint refers to as "F.G." For F.G.'s hospital stay from June 4-10, 1997, the total amount of overcharges for drugs and medical supplies, by "[a] conservative estimate[,]" was $1,185.03. *Id.* ¶ 35. On June 17, 1997, Providence submitted to the Medicare Intermediary a claim for services rendered to F.G. which included the $1,185.03 in overcharges.

Providence did not receive payment from Medicare for those overcharges, however, due to the method of reimbursement used under the Medicare system. In fact, those charges were not used in any way to calculate the amount owed to Providence for F.G.[1]

Near the end of 1997, Providence submitted an annual Cost Report covering the period from July 1, 1996 through June 30, 1997. That Cost Report, which is attached to and made part of the complaint, sets out total annual costs for "Medical Supplies" and "Drugs Charged to Patients" at approximately $3.3 million and

[1] The Medicare reimbursement system is explained in more detail in the legal analysis section, *supra* p. 7.

$3.6 million, respectively.

Procedural Background

This action, which is brought under the False Claims Act, was filed on April 19, 1999, naming as defendants Daughters of Charity National Health System, Inc., d/b/a Providence Hospital and Seton Medical Management, Inc. Pursuant to 31 U.S.C. § 3730(b)(2), the case was sealed prior to the service of process to allow the government an opportunity to investigate and decide whether to intervene. The sealed period was extended several times at the government's request 31 U.S.C. § 3730(b)(3). In August 2001, the government filed notice that it did not intend to intervene. (Doc. 17.) Due to questions regarding plaintiff's legal representation, the sealed period was further extended until March 28, 2002, when an order was entered unsealing the case and requiring service upon the defendants.

On May 15, 2002, plaintiff filed a first amended complaint adding Ascension Health, Inc. as a defendant. Subsequently, all defendants filed motions to dismiss. In response, the plaintiff filed a motion for leave to amend the complaint.[2] The Court granted the motion for leave to amend and terminated the pending motions to dismiss without prejudice to defendants' right to file new motions to dismiss. Subsequently, defendants filed the motion to dismiss *sub*

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[2] While this action was pending, *United States ex rel. Clausen v. Laboratory Corp.*, 290 F.3d 1301, 1310 (11th Cir. 2002), *cert. denied* 537 U.S. 1105 (2003), was decided. In light of the *Clausen* decision, plaintiff concluded that it was necessary to file a second amended complaint in order to comply with the pleading requirements of Fed. R. Civ. P. 9(b). The Court permitted the amendment and informed the defendants that motions to dismiss would more appropriately be directed at the second amended complaint.

judice.

Issues Presented

Defendants raise two common issues in their motion to dismiss.[3] First, they argue that the complaint is due to be dismissed with particularity as required by Fed. R. Civ. P. 9(b). Second, defendants contend that the complaint does not state a claim upon which relief can be granted. In opposing the motion to dismiss, plaintiff argues that the complaint sufficiently states three potential FCA claims, all of which arise from the hospital's alleged practice of overcharging for prescription medicines and medical supplies: (1) inflation of the total cost of prescription medicines and medical supplies set out in the annual cost report submitted to Medicare by including overcharges to F.G. (2) inflation of the total cost of prescription medicines and medical supplies set out in the annual cost report submitted to Medicare due to a "systemic" practice of overcharging and (3) inflation of a category of costs known as "outlier costs" in the annual cost report submitted to Medicare.

LegalAnalysis

Before addressing these issues, some background in the

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[3] Defendants Daughters of Charity, Seton and Ascension raise additional grounds for dismissal based on plaintiff's failure to plead facts demonstrating their participation in the alleged fraud. Plaintiff's claims against these defendants are not, however, based upon their direct participation but on theories of derivative liability. Plaintiff contends that Daughters of Charity and Seton are either principals or agents of Providence and that Ascension is liable as a successor-in-interest to Seton. The Court need not consider the separate issues raised by these defendants, however, since plaintiff's ultimate success against them depends upon his ability to state a claim against Providence.

applicable law is necessary. The Court will first consider the standards of review governing motions to dismiss under Fed. R. Civ. P. 9(b) and 12(b)(6). Next, in order to determine whether a claim has been stated, the Court must determine the precise elements of a cause of action under the FCA. Finally, application of the standards of review and the FCA in this case requires a general understanding of the Medicare reimbursement system.

Rule 9(b) & Rule 12(b)(6)

Because the FCA is a fraud statute, the pleading requirements of Fed. R. Civ. P. 9(b) apply. "Thus, ... a plaintiff must plead 'facts as to time, place and substance of the defendant's alleged fraud,' specifically 'the details of the defendants' allegedly fraudulent acts, when they occurred and who engaged in them.'" *Clausen v. Laboratory Corp.*, 290 F.3d at 1310. In *Clausen,* the Eleventh Circuit upheld the dismissal of a complaint for failure to plead an FCA claim with particularity.

A motion to dismiss under Rule 12 (b)(6) may be granted only "when the movant demonstrates 'beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.'" *Harper* v. *Blockbuster Entertainment Corp.*, 139 F.3d 1385, 1387 (11th Cir. 1998) (quoting *Conley v. Gibson,* 355 U.S. 41, 45-46, (1957)). In general, for purposes of a motion to dismiss, the Court must accept all the allegations of the complaint as true and construe the facts asserted in the light most favorable to the plaintiff. *Fortner v. Thomas,* 983 F.2d 1024, 1028 (11th Cir. 1993). However, allegations contradicted by facts set out in exhibits attached to or incorporated into the pleadings need not be taken as true. *United States ex rel Wilkins v. North American Constr. Corp.*, 173 F.Supp.2d 601, 617 (S.D. Tex. 2001).

Elements of a False Claims Act Claim

Plaintiff's lawsuit is brought under 37 U.S.C. §§ 3729(a)(1) and (a)(2) of the False Claims Act. Subsection (a)(l) makes it unlawful "to knowingly present or cause to be presented to an officer or employee of the United States Government ...a false or fraudulent claim for payment or approval." Subsection (a)(2) makes it unlawful "to knowingly make, use or cause to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the Government." Thus, in order to state a claim plaintiff must allege, at a minimum, facts to support the following elements: (1) the defendants made a claim or made a record or statement in support of a claim, (2) the claim or record or statement was false or fraudulent and (3) the defendants knew of its falsity. Submission of a false statement alone does not give rise to liability arises under the False Claim Act. *United States v. Southland Management Corp.* 326 F.3d 669, 674 (5th Cir. 2002) (en banc). "It is only those claims for money or property to which a defendant is not entitled that are 'false' for purposes of the False Claims Act" *Id.* 674-75. "There is no liability under this Act for *a false statement* unless it is used to get *a false claim* paid" *Id.* at 674 (emphasis added).

Every circuit court that has addressed the issue directly has held that the False Claims Act claim also requires proof of a fourth element-that the false submission was material.[4] *See, e.g., United States v. Southland Management Corp.* 326 F.3d 669, 679 n.3 (5th Cir. 2002) (en banc) (Jones, J., concurring) (collecting cases); *Hays v. Hoffman,* 325 F.3d 982

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[4] The Third Circuit has, in *dicta,* questioned whether materiality is an element of an FCA claim. *See United States ex rel. Cantekin v. University of Pittsburgh,* 192 F.3d 402, 415 (3rd Cir. 1999).

(8th Cir. 2002); *Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 732 (7th Cir. 1999); *United States ex rel. Berge v. Board of Trustees of the University of Alabama,* 104 F.3d 1453 (4th Cir. 1997); *see also United States v. TDC Management Corp., Inc.*, 24 F.3d 292, 298 (D.C. Cir. 1994) *(dicta).* Following the reasoning of these courts, this Court also concludes that a false claim must be material in order to be actionable under the FCA.

Medicare Reimbursement System

To determine whether any of plaintiff's claims allege a cause of action under the FCA, it is necessary to understand, first, how the Medicare reimbursement system operates. Medicare does not reimburse a healthcare provider for the actual charge submitted, nor is the reimbursement based upon that amount. Instead, "Medicare groups standardized medical codes for patients, diseases, and procedures into diagnostic related groups ('DRG') that provide the basis for [the] PPS [prospective payment system]. The average cost of care for each DRG determines the reimbursement amount, rather than the actual cost of care to a beneficiary." *United States v. Whiteside,* 285 F.3d 1345, 1346 (11th Cir. 2002). Health care providers are reimbursed at a preestablished flat rate for each DRG. *Transitional Hosp. Corp. of Louisiana, Inc. v. Shalala,* 222 F.3d 1019, 1021 (D.C. Cir. 2000). The reimbursement rates are based "on national and regional averages for the cost of treating particular illnesses and... not.. .on the cost to any particular hospital of treating particular DRG- classified illnesses." *Huntington Hosp. v. Thompson,* 319 F.3d 74, 76 (2nd Cir. 2003) (citing 42 U.S.C. § 1395ww(d)(l)(D)). In the case of patients whose hospital stays are "extraordinarily lengthy or costly" Medicare provides for additional reimbursements known as "outlier payments." *Transitional Hosp.,* 222F.3d at 1021.

Annual cost reports submitted by the health care provider are part of the reimbursement equation because they include certain costs, such as outlier costs, that may be reimbursed by Medicare in addition to those costs taken into account in the PPS/DRG payments. "[The] provider files annual cost reports setting forth information and calculations identifying the Medicare costs [such as outlier costs] that the hospital claims should be reimbursed by Medicare for that year. The cost reports include a certification that each cost report filed is true, correct, complete, and prepared from the books and records of the provider." *Id.*

General Allegations of Overbilling do not Satisfy Rule 9(b)

Plaintiff's claim regarding "systemic" overbilling by Providence is insufficient under Rule 9(b). There are no specific allegations as to time or place and only general allegations as to substance. In *Clausen,* the Eleventh Circuit held that the complaint under the FCA must allege, with particularity, at least one instance of a false claim being submitted. *Clausen,* 290 F.3d at 1312. Setting aside allegations with respect to F.G., which are discussed below, plaintiff has alleged: (1) that he is aware of other instances of overbilling for drugs and medical supplies based on his review of hospital records and (2) that "because these types of overcharges are systemic..., the Cost Report is greatly overstated as to drugs and medical supplies for patients." These are a series of conclusions, not facts. One cannot necessarily infer that the overbilling of particular charges to patient accounts is actually reflected in the cost report based simply on plaintiffs broad and conclusory allegations. Plaintiff has failed to make a specific allegation that the alleged "systemic" practice of overbilling resulted in the submission of a false claim for payment.

Even Specific Allegations of Overbilling do not Satisfy Rule 12(b)(6)

On the other hand, plaintiff's claim with respect to F.G. is specific with respect to time, place and substance of the alleged fraud and is, therefore, pled with sufficient particularity to satisfy Rule 9(b). However, neither this specific claim nor the more general claim discussed above states a claim upon which relief can be granted because it is apparent from the facts alleged and from the documents incorporated into the complaint that the alleged overcharges for medicine and medical supplies were not material to any claim for payment. A statement is material if it "has a natural tendency to... or is capable of influencing" the agency's decision whether to pay the claim. *Harrison,* 176 F.3d at 785.[5] First, it should be noted that with respect to F.G. plaintiff's claim is not based on any direct connection between the charges submitted to the fiscal intermediary and the specific payment to Providence for F.G.'s treatment. Whether those charges were true or false is irrelevant under the Medicare system because they did not affect the reimbursement decision. Any overcharges submitted with respect to F.G. (or any other individual) had no possibility of influencing the DRG

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[5] Some courts have relied on an alternative definition of materiality found in the Restatement (Second) of Torts § 538 (1977), which provides that a false statement is material if "a reasonable man would attach importance to its existence" or if the person making the statement knows or has reason to know that the recipient is likely to attach importance to it when making his decision. *Wilkins,* 173 F.Supp.2d at 635. Plaintiffs claim fares no better under this standard. A reasonable person would not attach importance to the amount of the statement submitted for payment where the amount of payment bears no relation to the amount claimed. Further, there are no facts asserted from which one might infer that Medicare or its fiscal intermediary attached any importance to the amount charged by Providence.

payment because that payment is fixed according to a reimbursement rate predetermined by Medicare.

Plaintiff alleges that the inflated amounts submitted are material in a broader sense. According to the complaint, these inflated charges for drugs and supplies were factored into the annual cost report, which then became the basis for "the computations considered by the Healthcare Financing Administration... which help to determine reimbursement rates for hospitals."[6] This allegation does not support materiality for two reasons.

First, the allegation is contradicted by the annual cost report itself. To demonstrate the method of the fraud, *i.e.,* that overcharges for drugs and medical supplies were included in the annual cost report, plaintiff has included with the complaint both the annual cost report and portions of a *worksheet* that was attached to that report. Plaintiff points out that on Worksheet A "Medical Supplies Charged to Patient" (item 55) are $3,329,717 and "Drugs Charged to Patients" (item 56) are $3,540,291. According to plaintiff, the amounts overcharged to F.G. and to other patients must be included in these worksheet totals. Therefore, plaintiff contends that the cost report is inflated. The trouble with plaintiffs theory is that the worksheet is not the cost report. These items-medical supplies and drugs-are listed on the worksheet under the heading "Ancillary Service Cost Centers," but those costs are not actually claimed on the annual cost

[6] The Court questions whether the inclusion of such data in a subsequent cost report would fulfill the FCA requirement that the statement be made "in support of a claim" since individual claims are submitted throughout the fiscal year and the report is not used to determine DRG reimbursements for the prior year.

report.[7] The cost report lists the "Ancillary Service Pass Through Cost" filed as $0. Because these overcharges were not actually claimed on the cost report, no false claim was submitted.

Even if overcharges for medicine and medical supplies had been included in the cost report, they would not support an FCA claim because, insofar as that report is concerned, these overcharges are not a claim for payment. As discussed above, plaintiff's theory is that inclusion of these overcharges on the annual report became part of the data used by Medicare to determine the amount of future DRG reimbursements rates. Submitting false data unrelated to a claim for payment is not prohibited by the FCA.

Plaintiff's Claim not Asserted in Complaint

In response to the motion to dismiss, plaintiff has conceived a new false claim theory not asserted in the complaint. According to this theory, the practice of overbilling may have been reflected in "outlier" payments which are a part of the cost report. Plaintiff admits that there were no outlier payments for F.G. but speculates that there may have been such payments for other patients as a result of overbilling. Because evidence that would support plaintiff's theory is

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[7] Plaintiff s complaint included only one page of the Worksheet A, which begins with line 41 and includes "Medical Supplies Charged to Patients" and "Drugs Charged to Patients" on lines 55 and 56. Along with its motion to dismiss, defendant has provided a complete copy of Worksheet A, from which it is clear that lines 37 through 59 are "Ancillary Cost Centers." When a plaintiff refers to documents central to the complaint, the Court will consider those documents *in their entirety* as part of the pleadings, even where the documents were not made a part of the complaint *Cf. United States ex rel. Brooks v. Blue Cross and Blue Shield of Florida, Inc.*, 116 F.3d 1364, 1369 (11th Cir. 1997) (on Rule 12(b)(6) motion permissible to consider documents provided by defendant as part of pleadings because those documents were central to complaint).

exclusively within defendants' control, plaintiff argues that the pleading requirements of Rule 9(b) should be relaxed to allow his claim to proceed

The difficulties with plaintiff's proposal to proceed with the unpled claim are twofold. First, neither the complaint, the amended complaint, nor the second amended mentions the outlier theory. This is not a claim that plaintiff has merely failed to state with particularity; rather, it is a claim that plaintiff has failed to assert at all. Plaintiff has offered no excuse for his failure to assert claim earlier, despite having had three opportunities to do so. For that reason alone, plaintiff's outlier theory does not save this action from dismissal.

Even if the complaint could be read to include a claim based on this theory, it is not pled with particularity and there is no reason to relax Rule 9(b)'s specificity requirement. Citing an unpublished Eleventh Circuit opinion, *Hill et al. v. Morehouse Medical Assoc., Inc.*, No. 02-14429 (11th Cir. Aug. 15, 2003), plaintiff argues that his outlier theory is sufficient to withstand Rule 9(b) scrutiny. In *Hill*, a panel of the Eleventh Circuit reversed the district court's dismissal on plaintiff's FCA claim for failure to plead with particularity and, in so doing, distinguished *Clausen*.

Both *Hill* and *Clausen* recognized that Rule 9(b)'s heightened pleading requirements may be relaxed when evidence of fraud is exclusively within the defendant's control. *Clausen* held, however, that relaxing those requirements is not appropriate where the plaintiff can assert nothing but conclusory allegations of fraud. In contrast, the *Hill* panel found that the plaintiff's allegations were sufficiently specific, although they did

not provide patient names or dates of claims, because:

> Unlike the plaintiff in [*Clausen*], however, Hill worked in the very department where she alleged the fraudulent billing schemes occurred—MMA's billing and coding department. Thus, she has firsthand information about MMA's internal billing and the manner in which the fraudulent billing schemes were implemented. Moreover, she alleged that she observed MMA billers, coders, and physicians alter various CPT and diagnosis codes over the course of seven months and thus submit false claims for Medicare reimbursement to the government. Throughout her complaint, she identified the confidential documents within MMA's exclusive possession that contain additional evidence of fraud. In addition, she supported her legal theory with facts describing MMA's billing process, the specific CPT and diagnosis codes that were altered...and the frequency of submission of each type of claim. Furthermore, in some instances, Hill provided the names of the employees and physicians who were responsible for making the fraudulent changes and the clinics where the codes were altered. Most important, however, unlike the plaintiff in [*Clausen*], Hill was privy to MMA's files, computer systems, and internal billing practices that are vital to her legal theory, because she worked in MMA's billing and coding department for seven months.

Hill, p. 12.

Plaintiff's similarity with Hill begins and ends with the fact that he is a former employee of one of the defendants. Although plaintiff observed overbilling to *patient's* accounts, he had nothing to do with the billing process, with the submission of Medicare claims or with the Medicare payment process in general. In short, his status as a former insider did not provide him with any specific knowledge about Medicare billing or claims practices. The plaintiff in *Hill* knew from personal observation that specific information, such as patient names and dates of services, existed but could not provide it in the complaint because that information was within defendant's control. Plaintiff has asserted no firsthand knowledge to support his theory that outlier payments were increased due to a systemic practice of overcharging patient accounts. In contrast to Hill, plaintiff in this case does not know whether such information exists at all. Instead, he is more like Clausen, whose complaint fell short because he could not identify any actual claim submitted for payment, only claims that were likely or possible. *Clausen*, 290 F.3d at 1313.

Conclusion

Despite three opportunities to amend his complaint, plaintiff has failed to plead sufficiently any claim that would entitle him relief under the False Claims Act. Plaintiff has alleged that defendant Providence has engaged in a systemic practice of overbilling Medicare patients. However, the Medicare reimbursement process is a complicated one which, for the most part, is not based on the amount charged by the health care provider, and plaintiff has failed to assert any facts to demonstrate how Providence's billing practices might be material to Medicare's payment of claims. Therefore, the defendants' motion to dismiss due to be and hereby is **GRANTED.**

DONE and **ORDERED** this the 28th day of January, 2004.

S/CHARLES R. BUTLER, JR.
UNITED STATES DISTRICT JUDGE

(3)

No. 04-566

Supreme Court, U.S.
FILED
NOV 24 2004
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In The
Supreme Court of the United States

UNITED STATES OF AMERICA,
EX REL., J. EDWARD WALTERS,

Petitioner,

v.

THE DAUGHTERS OF CHARITY NATIONAL
HEALTH SYSTEM, PROVIDENCE HOSPITAL,
SETON MEDICAL MANAGEMENT, INC.,
AND ASCENSION HEALTH, INC.,

Respondents.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eleventh Circuit**

PROVIDENCE HOSPITAL'S RESPONSE TO PETITION FOR A WRIT

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QUESTION PRESENTED

Whether a factually correct Cost Report constitutes a false claim under the False Claims Act, 31 U.S.C. §3729, *et seq.*, because worksheets not considered in determining future payment rates were appended to the Cost Report?

CORPORATE DISCLOSURE STATEMENT

Daughters of Charity National Health System, Inc. is a Missouri non-profit corporation, with its principal place of business in St. Louis, Missouri. Ascension Health is the sole corporate member of Daughters of Charity National Health System, Inc.

Providence Hospital is an Alabama not-for-profit corporation, with its principal place of business in Mobile, Alabama. Ascension Health is the sole corporate member of Providence Hospital.

Seton Medical Management, Inc. is an Alabama not-for-profit corporation, with its principal place of business in Mobile, Alabama.

Ascension Health is a Missouri non-profit corporation with its principal place of business in St. Louis, Missouri. Ascension Health is the sole corporate member of Daughters of Charity National Health System, Inc. Ascension Health is the sole corporate member of Providence Hospital.

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STATEMENT OF THE CASE

Providence Hospital ("Providence") was a Participating Provider for Medicare and Medicaid services with the United States Health Care Financing Administration ("HCFA") and its successor agency, the Center for Medicare and Medicaid services ("CMS"). In 1997 Providence submitted an Annual Cost Report covering the periods from July 1, 1996, through June 30, 1997. Annual Cost Reports submitted by hospitals are used by the Secretary of Health and Human Services ("Secretary") to determine future payment rates to Participating Providers.

Providence's 1997 Cost Report was filed along with worksheets showing calculations. The Secretary only considered the Cost Report itself, not the worksheets, in setting future payment rates. One of those worksheets, Worksheet A, included sums expended for "Medical Supplies Charged to Patient" and "Drugs Charged to Patients," both under the Worksheet headed "Ancillary Service Cost Centers." However, the Cost Report itself listed the "Ancillary Service Pass Through Costs" as $0.

Petitioner filed his lawsuit pursuant to the False Claims Act ("FCA"), 31 U.S.C. §3729, *et seq.*, alleging, among other things, that the Cost Report constituted a false claim because it might have been used, along with cost reports from all other participating providers throughout the country, to determine future payment rates. The trial court dismissed the claim for failure to state a cause of action. First, the Cost Report itself refuted the allegations, as the costs at issue were not included and therefore no false claims under Petitioner's theory were ever submitted. Second, the alleged overcharges, even had they

been included in the Cost Report, were not claims for payment.

ARGUMENT

Petitioner's request for a writ of certiorari is based on both factual and legal errors. It is further flawed in that it would expand the body of potential *qui tam* relators from whistleblowers with actual knowledge to the entire universe of potential plaintiffs hoping to search for a lawsuit through discovery.

Petitioner's factual basis for the Writ is his allegation that Respondent Hospital misstated costs in its Annual Cost Report, thereby causing inflation in the costs owed by the Secretary of Health and Human Services in determining reimbursement rates. *Petition*, p. 6. This is factually incorrect. As the trial court noted,

> the allegation is contradicted by the Annual Cost Report itself. . . . The trouble with Plaintiff's theory is that the worksheet is not the cost report. Those items – medical supplies and drugs – are listed on the worksheet under the heading 'Ancillary Service Cost Centers,' but those costs are not actually claimed on the Annual Cost Report. The Cost Report lists the 'Ancillary Service Pass Through Costs' filed as $0. Because these overcharges were not actually claimed on the Cost Report, no false claim was submitted.

Pet.Supp.App., p. 12.

There is simply nothing for this Honorable Court to consider, for no inflated costs were submitted. The factual premise of Petitioner's argument is flawed. Absent any

inflation of costs, there was nothing for the Secretary to consider, and there was no claim that could be false.

Petitioner's argument suffers another crucial factual flaw, the absence of a claim for payment. The alleged overstatements found in Providence's worksheets were not claims for payment. Petitioner posits that such calculations could be used by the Secretary in determining future payment schedules. However, as the trial court noted, "[s]ubmitting false data unrelated to a claim for payment is not prohibited by the FCA." *Pet.Supp.App.*, p. 12. The trial court's ruling, and the appellate court's affirmation of same, are consistent with this Honorable Court's pronouncement in *United States v. McNinch*, 356 U.S. 595, 599, 78 S.Ct. 950, 2 L.Ed.2d 1001 (1958), "'the conception of a claim against the government normally connotes a demand for money or for some transfer of public property.'" quoting *United States v. Tieger*, 234 F.2d 589, 591 (3rd Cir. 1956). accord *United States v. Bornstein*, 423 U.S. 303, 309 fn. 4, 96 S.Ct. 523, 46 L.Ed.2d 514 (1976). This Honorable Court has, in one instance, found "claim" as used in the FCA sufficiently expansive to reach loan applications, but even that case was limited to false statements "made with the purpose and effect of inducing the Government immediately to part with money." *United States v. Neifert-White Co.*, 390 U.S. 228, 232, 88 S.Ct. 959, 19 L.Ed.2d 1061 (1968). In the instant cause Petitioner theorizes only that data from Providence might be a small part of calculations to determine future payments. No immediate parting of money was alleged. The worksheets were not demands for money or property, and they were not prepared to induce the Government to immediately part with money. Even had they been submitted as part of

Providence's Cost Reports, they could not form the basis for FCA liability, as they were not claims.

Petitioner alleged certification was proper to resolve conflict amongst the Circuit Courts of Appeal. There is no such conflict.

The Court below quoted *United States ex rel. Clausen v. Laboratory Corporation of America,* 290 F.3d 1301, 1311 (11th Cir. 2002), *cert. denied*, 537 U.S. 1105, 123 S.Ct. 870, 154 L.Ed.2d 774 (2003), "[w]ithout the presentment of . . . a [false or fraudulent] claim, while the practices of an entity that provides services to the Government may be unwise or improper, there is simply no actionable damage to the public fisc as required under the FCA." *Pet.App.* A-6. Petitioner argued this ruling conflicts with rulings from the Tenth and Fourth Circuits. He is not correct.

Petitioner's claim of conflict relies entirely on the conclusion of the above-quoted sentence rather than the underlying premise. The underlying premise of the sentence is the absence of a claim, not damage to the public fisc. The *Clausen* court concluded 'without a claim, there is no false claim damaging the public fisc.' Petitioner, searching for conflict, misreads the decision to state 'absent damages to the public fisc, there can be no FCA claim' and from this erroneous reading finds conflict.

The Tenth Circuit Court of Appeals' decision in *Kennard v. Comstock Resources, Inc.* 363 F.3d 1039 (10th Cir. 2004), did not address the absence of a claim. The existence of a claim was not disputed. Rather, the *Kennard* court interpreted a section of the False Claims Act, 31 U.S.C. §3729(a)(7), not at issue in the instant cause. That section of the statute provides that "a false record or statement to conceal, avoid, or decrease an obligation to

. . . transfer money . . . to the Government" is actionable. Thus, the Court ruled, while the Government was not the ultimate recipient of the funds and therefore suffered no damages, the false claim made in transferring royalties to the Government for further disbursement to an Indian Tribe was actionable under the FCA. In *Kennard* there was a claim that was false. In the instant cause, there was no such claim. There is no conflict.

Petitioner's analysis of conflict suffers the same deficiencies in discussion of *Harrison v. Westinghouse Savannah River Co.*, 352 F.3d 908 (4th Cir. 2003), and *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776 (4th Cir. 1999). Both decisions arose from the same conduct. Just as in *Kennard*, claims containing falsities were submitted, and were actionable, though the Government suffered no quantifiable monetary damages.

In the instant cause, contrary to Petitioner's repeated assertions, no false claims were submitted. The alleged falsities identified by Petitioner were found only in the worksheets. The Annual Cost Report itself, the document Petitioner alleged contained a false claim, did not contain any such falsity. Respondent does not dispute that a false claim may be actionable under the FCA where said falsity is material to the Government's payment decision, even absent damages. However, no actionable cause lies under the FCA, damages or no, absent a claim that is false.

Petitioner, in his conclusion, argued that the *qui tam* provisions of the False Claims Act should not be limited to Relators with insider knowledge. He stated "if the courts are going to allow individuals and corporations to scam the system because False Claims Act plaintiffs have not participated in the fraud and thus, do not have insider

knowledge, as was the situation in this case, the weapon is ineffectual for the great majority of fraud against the Government and taxpayers." Petitioner's theory that plaintiffs lacking insider knowledge should be permitted to come forward as *qui tam* relators, and then search for lawsuits through discovery, is contrary to the purpose of the False Claims Act.

The purpose of the False Claims Act is to encourage "private individuals who are aware of fraud being perpetrated against the Government to bring such information forward," H.R.Rep. No. 660, 99th Cong., 2d Sess. 22 (1986). The whistleblower section of the False Claims Act, 31 U.S.C. §3730, permits only the "insider/'whistleblower'" to maintain a *qui tam* action. *Hindo v. University of Health Sciences/The Chicago Medical School*, 65 F.3d 608, 612-613 (7th Cir. 1995), *cert. denied*, 516 U.S. 1114, 116 S.Ct. 915, 113 L.Ed.2d 846 (1996). The whistleblower provision "is intended to encourage those with knowledge of fraud to come forward," *Robertson v. Bell Helicopter Textron, Inc.*, 32 F.3d 948, 951 (5th Cir. 1994), *cert. denied*, 513 U.S. 1154, 115 S.Ct. 1110, 130 L.Ed.2d 1075 (1995), not to encourage plaintiffs to come forward in search of fraud.

The whistleblower provision of the False Claims Act is specifically intended by Congress to encourage insiders with knowledge of fraud to come forward. Petitioner's conclusion that such limitation would render the False Claims Act "ineffectual" merely demonstrates the failure to understand the purpose of the False Claims Act.

CONCLUSION

Petitioner's request for review is based on misstatements of fact, misstatement of law, and failure to understand the basic purpose of the False Claims Act.

This Honorable Court should DENY Petitioner's Request for a Writ of Certiorari.

Respectfully submitted,

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